Multi-Agency Guidance for Injuries in NON-MOBILE Babies

Version: South Glos and Bristol multi agency working group
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Ratified by: South Glos, Bristol and N Somerset Safeguarding Children Boards

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Of those children born in the 2 large maternity units in Bristol (approx 11,000 births per year) up to 4 will suffer serious injury such as abusive head trauma every year.

1. AIM OF GUIDANCE

The aim of this Guidance is to ensure that professionals in all agencies:

1. are aware that even minor injuries could be a pointer to serious abuse in non-mobile babies
2. know that such injuries, however plausible, must routinely lead to multi-agency information sharing
3. know how to refer such a baby for a medical opinion
4. know whom to contact for safeguarding purposes.

2. TERMINOLOGY

Baby: a young and/or developmentally immature child. This Guidance uses the term 'baby' rather than 'infant' (an infant is defined as a baby less than 12 months of age) to recognise that some babies over 12 months will not be independently mobile eg disabled babies.

Injury: injuries such as bruises, fractures, burns/scalds, eye injuries eg sub-conjunctival haemorrhages (bleeding into white of the eye), /corneal abrasions, bleeding from the nose or mouth, bumps to the head. Scratches may be self-inflicted by babies and professionals can use their judgement or discuss with a senior as to whether the child needs to be examined by a paediatrician or not.

Mobile: a baby who can crawl, pull to stand, 'cruise' around furniture, or is toddling.

Non-mobile: babies who cannot do any of the above. Babies who can roll are classed as **non-mobile f**or the purposes of this document. Professionals must use their judgement regarding babies who can sit independently but cannot crawl, depending on severity of the injury and its plausibility.

MIU : Minor Injuries Unit

USING PROFESSIONAL JUDGEMENT: This document is written on the understanding that professionals are allowed to use their professional judgement and common sense. Professional judgement is based on your experience, training and role. However, it is important to remember that non-accidental injuries often occur in the same body areas as accidental ones, and professionals are often seduced by plausible explanations. Professional judgement may for example mean allowing a family to take a well baby with a plausible minor injury home from a busy surgery or emergency department before the doctor is able to make checks through social care, but advising the family that they will be called within 24hrs once checks have been made. Social care and police checks are just as important a part of the safeguarding net around the child as the medical examination, and the 2 should take place together, in parallel, to allow professionals to make a risk analysis together.

Even senior, experienced professionals would be advised to discuss cases with peers or senior colleagues if deciding <u>not</u> to follow the guidance. Such colleagues could be your line manager, your safeguarding lead, or a consultant community paediatrician. Reasons for such decisions must be clearly documented. Professionals not working in Health should ALWAYS discuss an injury in a non-mobile baby with a Healthcare professional asap.

3. RESEARCH FINDINGS

- Bruising in a baby who has no independent mobility is very uncommon – less than 1% of non-mobile babies will have bruises. It may be an indicator of a serious medical condition or physical abuse.

- Accidental bruising occurs in approximately 17% of babies who are cruising (1 to 5 bruises).

- Severe child abuse is 6 times more common in babies aged under 1 year than in older children.

- Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission

- Oronasal bleeding (bleeding from the nose and/or mouth) in infants has been proposed as a marker of child abuse and requires investigation by a paediatrician

- Abusive Head Trauma (AHT) – previously described as Shaken Baby Syndrome – is a relatively common cause of childhood neuro-trauma with an estimated incidence of 14-40 cases per 100,000 children under the age of 1 year; 15-23% of these babies die within hours or days after the incident. Of those who survive AHT, one third are severely disabled; one third are moderately disabled; one third have mild or no lasting symptoms.

Infants under the age of one are more at risk of being killed at the hands of another person (usually a carer) than any other age group of child in England and Wales. Non-mobile babies cannot cause injuries to themselves and therefore must be considered at significant risk of abuse. Multi-agency information sharing allows for sensible, informed judgements regarding the child's safety to be made.

4. BENIGN SKIN MARKS

This Guidance refers only to injuries. Where it is believed a skin mark could be a birth mark or similar benign medical skin condition, professionals should be encouraged to use their judgement. Midwives/ Health Visitors/ GPs should check for and record any birthmarks, or injuries that have occurred as a result of the birth itself, including recording in Parent Held Record (Red Book) so other professionals can see this (with parental permission). If any doubt exists about the nature of a skin mark, the baby's parents / carers should be requested to seek a medical opinion from their GP. Photographic documentation is very helpful.

5. ASSESSMENT (Professionals may wish to use Best Evidence Safeguarding Tool to aid assessment – "BEST" - see Appendix)

In **ALL CASES** of observed injury an explanation should be sought, and the explanation(s) recorded. Arrangements must be made for non-mobile babies to be fully examined. It is imperative that the professional does **not** suggest to the parent/carer how the injury occurred.

Any explanation for the injury should be critically considered within the context of:

- **The nature and site of the injury**
- **The baby's developmental abilities**
- **The family and social circumstances including current safety of sibs/other children**

It is fundamental that the assessment of the family & social circumstances, including the analysis and decision making, is documented. Particular attention should be paid to whether the reported **mechanism is inconsistent with the injury and to any abnormal behaviour of the child or family**.

All those living within the family home, and partners who do not live there but participate in the child's care, must be considered as part of the assessment.

1. MOBILE BABIES PRESENTING WITH AN INJURY

Babies who are pulling to stand/cruising/crawling/toddling are more prone to accidental injuries. These may present to Primary Care or other agencies eg nurseries/child minders. Where a professional has assessed that a *paediatric* examination is *not* required for a mobile baby, consideration should still be given as to whether it is felt the baby has suffered or is at risk of suffering significant harm. Use of the University Hospitals Bristol Best Evidence Safeguarding Tool (Appendix) is recommended to assess safeguarding issues for such injuries. Discussion with the on-call community paediatrician and/or Social Care should be considered. An assessment by GP or other health care professional may be appropriate. Follow normal safeguarding procedures ("Working Together" and South West Child Protection Procedures).

7. NON-MOBILE BABIES PRESENTING WITH AN INJURY

Due to the significant risk of abusive injury in a non-mobile baby **ALL non-mobile babies with an injury** should be referred to a Hospital or Community Paediatrician, or Emergency Department (ED) with trained paediatric staff, even if there is a plausible explanation. If the injury seems minor (eg small bruise in a baby who is otherwise well), the professional can contact the on-call Consultant Community Paediatrician the same day (via BRI switchboard 0117 9230000) to discuss the case rather than send the child immediately to the ED. Usually examination will be arranged for the same day/within 24 hours. Any other non-mobile baby with an injury should be seen without delay at the Children's Hospital Emergency Department, including those with bleeding from the nose, mouth and/or ear. If there is any uncertainty about the severity of the injury and where to refer it should be discussed with the on-call community paediatrician. Paramedics/first responders may have useful information about home conditions and paediatricians should consider obtaining information from them.

Where a non-mobile baby with an injury presents at an ED or Minor Injuries Unit (MIU) he/she must be seen by a doctor of at least registrar status or by a paediatrically trained nurse practitioner. If such staff are not working at the ED/MIU, the child must be referred to the Bristol Royal Hospital for Children or similar facility. After full examination and multi-agency checks, the baby should be discussed with, or preferably reviewed by, a Consultant Paediatrician (Hospital/Community) or ED Consultant with Paediatric training.

Consultant Paediatricians (ED, Hospital, or Community) have the right to use their judgement when considering injuries in non-mobile babies, and in certain situations may deem it

unnecessary for a baby to be brought to hospital to be examined by a paediatrician. In such instances, the reasons must be clearly documented (e.g minor injury witnessed by a professional, or GP considers mark is most likely a Mongolian Blue Spot and will review). Risk analysis including multi-agency checks should still be considered.

Repeated minor injuries in non-mobile babies are extremely concerning.

8. MAKING A REFERAL TO THE PAEDIATRIC SERVICE AND SOCIAL CARE

Where the professional has identified that a referral should be made to the Emergency Department or Community Paediatrician, the baby's parent / carer should be informed that a person with parental responsibility will be required to attend with their baby or at the very least give consent for a medical examination to take place. The professional should give to the ED or Paediatrician the name and date of birth of the baby, and contact details of parent/carer so they can be contacted if they do not arrive. The professional should discuss with the parent/carer how they will get to hospital (arranging an ambulance if necessary) and should ALWAYS contact the hospital the next working day to confirm that the baby has attended.

Where the baby is KNOWN to Social Care the professional should always contact the allocated Social Worker to make him / her aware of events and discuss any actions taken or required.

Where the baby is NOT KNOWN to Social Care but the professional deems the baby to be at risk of significant harm a referral to Social Care should be made following the South West Child Protection Procedures. Professionals should contact their line manager urgently if they require advice/guidance in following this process.

If the baby is NOT MOBILE AND NOT KNOWN to Social Care the parent/carer should be informed that all non-mobile babies with any injury require a medical examination and are discussed with Social Care. If the injury seems minor (eg a small bruise in a baby who is otherwise well), the professional can contact the on-call consultant community paediatrician (via BRI switchboard 0117 9230000) to arrange an examination (usually the same day). In all other cases the professional should refer the child to the nearest Emergency Department with a paediatric service (usually the Bristol Royal Hospital for Children). If uncertain where to refer, or if baby has presented at a Walk in Centre / MIU, discuss with consultant community paediatrician on call.

The professional must contact First Response/Access and Response Team ART/Emergency Duty Team to:

- Request a check of relevant carers by Social Care. In cases of injury to **non-mobile babies**, Social Care (not the referrer) will contact Police to check carers, since police may be the only agency to hold relevant information re violent crime or abuse.
- make Social Care aware of events and discuss any action required.
- Inform Social Care where the child has been sent for an examination so that Social Care can share relevant information with that clinician.

Dates of birth of all children and parents/carers should be available when calling Social Care if possible. The safety of sibs/other children must be considered.

The professional may negotiate with hospital staff that they contact Social Care once the baby is seen, if more appropriate. In most cases however, the referring professional will be

best informed and should make the call to First Response/Access and Response Team ART/Social Care/Emergency Duty Team, quoting that they are following the "injuries in non-mobile babies" guidance.

- Social care should inform the referrer and Paediatrician of the outcome of checks. If the baby/family is known to Social Care or Police the Social Worker must ensure the Paediatrician is aware of all relevant information, including historical concerns.

- **Daytime Social Care must handover to EDT before 5pm** unless multi-agency discussions (including with Health) have been completed and the baby is discharged.

Hospital must inform Primary Care (GP/HV/midwife).

A strategy discussion between Social Care, Police and Health may take place. The Social Worker may wish to attend the examination.

It is only necessary for one person with parental responsibility to give consent for examination. In a situation where all persons with parental responsibility **refuse consent** for a non-mobile baby with an injury to be medically examined, (or an injury in a mobile baby which concerns a professional) the professional should discuss the matter with their line manager as a matter of priority. The line manager should contact the Consultant Community Paediatrician on call (via BRI switchboard 0117 9230000) to establish whether a medical examination is definitely required. **If an examination is deemed necessary, Social Care's immediate involvement is essential and a referral should be made by the attending professional.**

9. THE MEDICAL EXAMINATION

The Paediatrician should take into account the developmental capabilities of the baby and all information provided when the cause of the injury is being assessed.

Accidental Cause

- If the cause of the injury is felt to be accidental, the Paediatrician should still ensure that families of non-mobile babies are checked via Access and Response Team ART/ First Response/Social Care/EDT who will liaise with police. If it is then judged that the baby has been abused/neglected, or is at risk of significant harm, a referral to Social Care should be made in accordance with the South West Child Protection Procedures.

- If after multi-agency checks it is judged that the injury is accidental but the baby already has an allocated Social Worker (SW), the Paediatrician must ensure that the SW is informed in writing of the outcome of the medical examination.

- The Paediatrician must inform the referring professional and Primary Care (and other professionals as appropriate) of the outcome of the medical examination and of any support/safeguarding intervention being taken. This can be done via discharge summary.

Possible Non-Accidental Cause

- Take steps to immediately safeguard the baby according to South West Child Protection Procedures.

- Where the baby is unknown to Social Care a referral should be made immediately.

- Discuss with the Social Worker the outcome of the medical examination and any follow-up action required. Both should be clear about what actions are to be taken and who is

responsible for implementing these actions. Consider supervision of parent/carer on ward.

- Social Worker or Health Professional must report to the Police without delay where there is concern about a child's welfare which constitutes or may constitute a criminal offence against a child. This is to protect the baby and any other children from risk of serious harm.

- Inform the referring professional of the outcome and of any action being taken.

- Nursing staff in the hospital must inform and update the Safeguarding Children Named Nurse/Team who can then aid liaison with relevant professionals.

- Record discussions and outcomes in the medical notes. Add an appropriate note in Parent Held Record (Red Book).

- Disagreement between professionals regarding the safety of a child must be resolved using the relevant Safeguarding Board's Resolution of Professional Differences/ Escalation Policy (held on LSCB websites).

RELATED POLICIES, PROCEDURES AND GUIDANCE

- SW Child Protection Procedures http://www.online-procedures.co.uk/swcpp/
- Working Together 2013 Signs and symptoms of possible child abuse Bruising
- NSPCC information leaflet http://www.nspcc.org.uk/search/?query=core%20info
- Cardiff Child Protection Systematic Reviews http://www.core-info.cardiff.ac.uk/

RESEARCH:

1. Maguire S, Mann MK, Sibert J, Kemp A. Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? *Archives of Disease in Childhood* 2005;**90**:182-6

2. Maguire S. Bruising as an indicator of child abuse: when should I be concerned? Paediatrics and Child Health 2008;18(12):545-9

3. Kemp A, Maguire S, Nuttall D, Collins P, Dunstan F. Bruising in children who are assessed for suspected physical abuse. *Arch Dis Child* 2014;99:108-113

4. McIntosh N, Mok JY, Margerison A Epidemiology of oronasal hemorrhage in the first 2 years of life: implications for child protection. *Pediatrics* 2007; **120**(5):1074-8

5. Shantini Paranjothy, David Fone, Mala Mann, Frank Dunstan, Emma Evans, Alun Tomkinson, Jonathan Sibert and Alison Kemp. The incidence and aetiology of epistaxis in infants a population based study. ADC online 8th January 2009

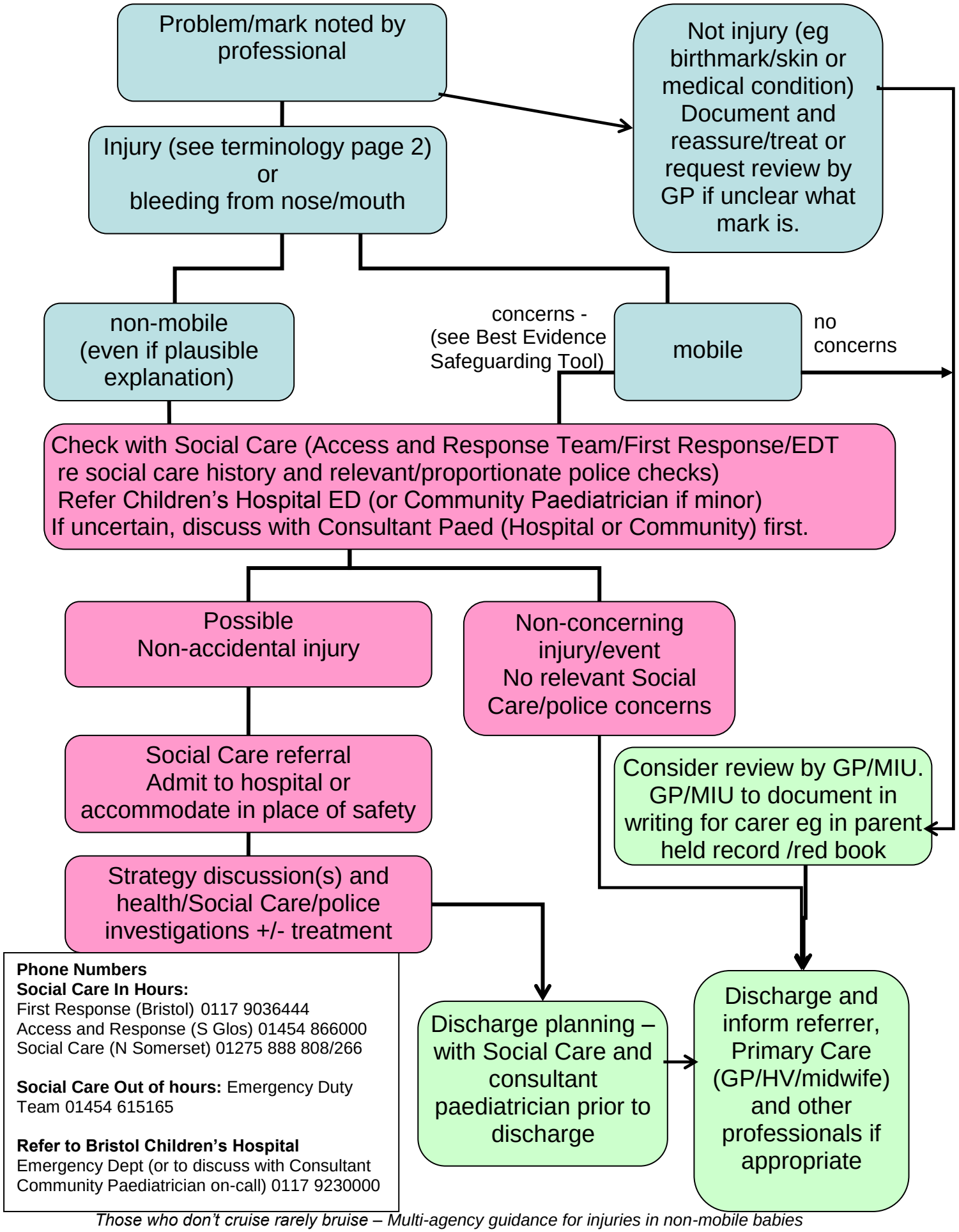
6. Shreiti Agrawal et al. Prevalence of Retinal Haemorrhages in Critically Ill Children. Pediatrics 2012; **129**;e 1388

7. T. Sieswerda – Hoogendocrn et al. European Journal of Pediatrics 2012. Abuse Head Trauma. **171**:415-423

8. Maguire S, et al. Archives of Disease in Childhood 2009. Which clinical features distinguish inflicted from non-inflicted brain injury? A systematic Review: **94**: 860-867

Thanks and acknowledgement to Dr Andrea Warlow and Western Bay PPP subgroup, Neath and Port Talbot Safeguarding Board, for permission to adapt their Minor Injuries in Babies Policy.

Flow chart for injuries in babies



Phone Numbers
Social Care In Hours:
First Response (Bristol) 0117 9036444
Access and Response (S Glos) 01454 866000
Social Care (N Somerset) 01275 888 808/266

Social Care Out of hours: Emergency Duty Team 01454 615165

Refer to Bristol Children's Hospital
Emergency Dept (or to discuss with Consultant Community Paediatrician on-call) 0117 9230000

Best Evidence Safeguarding Tool

University Hospitals Bristol NHS
NHS Foundation Trust

Do my parents / carers have any risky behaviours which may impact on how they look after me? Does a social worker know me?

NO DON'T KNOW YES

Do my parents / carers comfort and cuddle me? Do I respond to them?

NO DON'T KNOW YES

Was I being cared for safely when my accident happened?

NO DON'T KNOW YES

ADDRESSOGRAPH LABEL

Name: .....

Date of Birth: .....

Hospital No: .....

Ward / Hospital: .....

Have you fully undressed and examined me? Am I clean and well cared for?

NO DON'T KNOW YES

Have you witnessed / confirmed I am developmentally capable of doing what my parents / carers describe?

NO DON'T KNOW YES

Was I born prematurely, kept in hospital after birth or a low birth weight?

NO DON'T KNOW YES

If I have a fracture, burn or scald have you excluded these specific injury risks?

NO DON'T KNOW YES

Do I have any unexplained marks, bruises, petechiae, even if very small?

NO DON'T KNOW YES

Is the history of how I hurt myself clear, consistent and plausible?

NO DON'T KNOW YES

Did my parents / carers bring me promptly for treatment and give me first aid?

NO DON'T KNOW YES

Name.....

Signature.....

Date.....

Guidance Notes

Please answer all 10 questions by ticking the corresponding box.
If your infant patient has any red flags are they safe to be discharged without further assessment?
Amber flags should also be discussed with a senior colleague and Primary Care Team (GP or HV)

Indicators or Risky Fracture Presentations:

- Any fracture in a non-mobile infant.
- Metaphyseal fractures of any limb bone
- Rib fracture -'high risk'
- Spiral /oblique humeral fractures
- Multiple fractures / different ages

Other Risky Infant Presentations:

- No /Unclear /Changing history
- No ante-natal care
- Passive, watchful, fearful infant
- Delay in presentation
- Injury "caused by sibling "
- Lack of supervision at time of injury
- Attachment difficulties with premature / difficult babies
- Not comforted by parent when distressed (passivity)
- Previous Social Services contact
- Persistent DNAs
- Previous apparently plausible" attendances

Indicators of Risky Bruising Presentations:

- Any bruise in a non-mobile infant (can be a precursor to more serious injury or death) *Remember skin pigmentation / ethnicity may mask bruising*
- Bruising to the face, head (eye socket) back, abdomen, hip, upper arms, backs of legs, ears, hands or feet
- Multiple or clusters of bruising
- Severe bruising to the scalp, accompanied by swelling around the eyes and no skull fracture may result from 'scalping'

Indicators of Risky Burn/Scald Presentations:

- Clear 'tide mark' to limbs or demarcation line
- Bilateral lower limb involvement
- Symmetrical pattern / uniform depth
- Burns to dorsum of hands / soles of feet
- Sparing of the skin folds / centre of buttocks
- Associated injuries
- Evidence of neglect

Parental Risk Factors:

- Domestic violence
- Mental health issues
- Substance misuse
- Learning difficulties
- Social isolation
- Young parents
- Social deprivation / criminality
- Poor parenting experience / LAC

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